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ABSTRACT

This document illustrates the development and presentation of a workshop given to the King County Alcohol Training Consortium in King County, Washington as a 4-hour training session. It is divided into five sections and a bibliography. The first section explains the purpose of the booklet. Section II concerns the Alcohol/Elderly Network and briefly describes the King County Alcohol Training Consortium and the Seattle-King County Division on Aging Case Management Program. Section III looks at the issue of aging, giving general economics and population forecasts for King County and examining common concerns and feelings encountered when working with older adults. Section IV deals with alcohol and the elderly. This section provides a brief overview of aging and alcoholism, identifies some of the masks that alcoholisn can wear, and discusses family issues in elderly alcoholism. The final section describes a family conference. It discusses family intervention for families with elderly persons, provides guidelines for the family problem solving conference, explains dysfunctional behaviors in the family conference, considers family illness in children, and delineates family roles. An Adult Children of Alcoholics bibliography of 21 items is included. (NB)

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A CASE MANAGEMENT TEAM APPROACH FOR CLIENTS WITH CHEMICAL DEPENDENCIES

Barbara West

Kaylene Moon

CG 020921

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TABLE OF CONTENTS

SECTION I IDEA EXCHANGE

A. INTRODUCTION
B. PURPOSE OF BOOKLET

SECTION II ALCOHOL/ELDERLY NETWORK

A. KING COUNTY ALCOHOL TRAINING CONSORTIUM
B. SEATTLE-KING COUNTY DIVISION ON AGING CASE MANAGEMENT PROGRAM

SECTION III AGING

A. GENERAL ECONOMICS AND POPULATION FORECASTS FOR KING COUNTY
B. SPECIAL FACTORS IN WORKING WITH OLDER ADULTS
   1. COMMON CONCERNS
   2. COMMON FEELINGS

SECTION IV ALCOHOL AND ELDERLY

A. BRIEF OVERVIEW OF AGING AND ALCOHOLISM
B. THE MASKS ALCOHOLISM CAN WEAR
C. FAMILY ISSUES IN ELDERLY ALCOHOLISM

SECTION V THE FAMILY CONFERENCE

A. FAMILY INTERVENTION
B. GUIDELINES FOR THE FAMILY PROBLEM SOLVING CONFERENCE
C. EXPLANATIONS OF DYSFUNCTIONAL BEHAVIORS IN THE FAMILY CONFERENCE
D. FAMILY ILLNESS IN CHILDREN
E. FAMILY ROLES

SECTION VI BIBLIOGRAPHY

SECTION I IDEA EXCHANGE

A. INTRODUCTION

B. PURPOSE OF BOOKLET

SECTION I

A. INTRODUCTION

We perceive our relationships with the members of the King County Alcohol Consortium to be the basis of developing a team approach. We work with these member agencies to problem solve, to conduct family intervention conferences, and develop service plans for clients who need alcohol treatment.

We have always used the team approach with our own team members and other service providers. Our membership in the Alcohol Consortium has expanded this model.

B. PURPOSE OF BOOKLET

This booklet will illustrate the development and presentation of a workshop given to the King County Alcohol Training Consortium in July 1987. The format of the training was lecture, discussion and roleplay. The materials used in the workshop are included in the booklet to share in our Idea Exchange.

Participants in the workshop included enrollee representatives from elderly housing, alcohol treatment centers, detoxification centers, hospitals, health clinics, the Seattle Indian Health Board and Jewish Family Services.

Presenters representing the aging field:

Barbara West, M.A. in Public Administration, B.A. in Education. Taught creative writing classes to elderly and has been employed as Case Manager with the Seattle King County Division on Aging for nine years.

Kaylene Moon, B.A. Gerentology, M.A. in Applied Behavioral Science. Worked in field of aging since 1971. Holds four (4) certificates of training from King County Division of Alcohol and Substance Abuse Training Consortium. She has worked as a trainer for many Volunteer groups, taught Women in Aging at a Community College, has been a presenter and trainer at several Senior Centers and facilitated an Alzheimer Support Group. Presently is working as a supervisor in the Case Management program with Seattle King County Division on Aging.

A special thank you to Claudia Kish for Volunteering her time and typing skills to this project.

SECTION II ALCOHOL/ELDERLY NETWORK

A. KING COUNTY ALCOHOL TRAINING CONSORTIUM

B. SEATTLE-KING COUNTY DIVISION ON AGING
CASE MANAGEMENT PROGRAM

SECTION II

A. KING COUNTY ALCOHOL TRAINING CONSORTIUM

HISTORY: The King County Training Consortium was developed in 1986 to establish a mechanism for ongoing training for social service providers in King County who serve indiv duals with chemical dependencies. The goals of the Consortium are to enhance staff skills, enable counselors to meet their continuing education requirements, and encourage networking and interagency and cross-system collaboration.

GOALS: To provide an on-going program of training offerings that respond to the training needs of providers dealing with chemically dependent clients and their families.

BENEFITS: Training seminars are designed to enhance participants' understanding of alcohol and substance abuse issues and delivery. Seminars also provide opportunities for information sharing and networking to reduce service access barriers and facilitate client referral. All seminars are BASA approved to meet continuing education requirements for certified alcohol/drug counselors.

Since May, 1986, there have been 79 seminars offered as part of the King County Training Consortium. An average of between three and four seminars are held per month. Some of the seminars that deal with alcohol and elderly issues are:

"Medical Aspects of Alcoholism"

"Communication Skills with the Chemically Dependent Person"

"Assessing Mental Disorders in Alcoholic Clients"

"Loss and Unfinished Grief Work"

"Overview of Alcohol/Drug Resources"

"Medication and Alcohol in the Elderly"

'Successful Intervention with the Elderly: A Case Management/Team Approach"

"Addressing the Spectrum of Health Needs of the Chemically Dependent Person: Introduction to the Seattle-King County Health Department"

"Hidden Casualties: Adult Children of Dysfunction/ Alcoholism"

CONSORTIUM COMPOSITION:

Membership is open and participation encouraged from many disciplines and systems which relate to chemically dependent clients. Both public and private sectors are involved. Currently, the Consortium consists of 71 member agencies. Member agencies cross various disciplines, from the chemical dependency field to health care, mental health, State financial and social services, and criminal justice.

PARTICIPATION:

In exchange for an agency/program's provision of training, agency staff have access to the full range of offerings by the consortium.

The hours to be provided by an agency/program are determined on the basis of agency/program size and utilization factors. Each seminar will be provided in 4-hour blocks of time.

Agencies/programs sponsoring the training are responsible for the following:

1) submitting training application documentation

2) providing the training

3) seminar facility/equipment

4) administration of registration process

5) collection of evaluation forms

ROLE OF KCDASAS/ TRAINING COORDINATOR:

The Training Coordinator provides technical assistance for seminar development and general oversight and coordination of the training consortium. Specifically, selection of topics, determination of training hours to be provided, seminar scheduling, publicity and recruitment of new membership are performed by the Training Coordinator.

Seattle/King County Division on Aging

Case Management Program

PROGRAM INFORMATION SHEET

The goal of the Case Management Program is to enable older people to maintain independence in their own homes and communities. Case managers are specialists in conducting in-home assessments and then planning and coordinating the appropriate community-based care and services.

ELIGIBILITY

Our program serves King County residents who are 60 years of age or older. We specialize in helping those who are: low-income; homebound or isolated; in need of multiple services and unable to obtain them on their own; having increasing difficulty managing at home and at risk of nursing home placement.

SERVICES PROVIDED

Comprehensive Assessment: Case managers conduct a comprehensive psycho-social assessment of an older person's needs and capabilities. This assessment is done in the client's home.

Service Plan Development and Implementation: Case managers develop and implement a comprehensive care plan for obtaining needed benefits and services. This usually involves linking the client to income and health benefits, medical treatment, legal services, mental health treatment, alcohol treatment, and/or social and community support services such as chore, home health and housing. Case managers also provide short term counseling and direct services as needed.

Frequency of Contact: The minimum amount of contact a case manager is required to have with a client is the initial home visit, three reassessment home visits, and monthly contact by telephone. Almost all clients receive significantly more than this minimum requirement. The case managers maintain an average caseload of 50 clients.

Ongoing Case Management and Termination Planning: Case managers make sure that benefits and services are received and monitor their effect on the client's ability to remain independent. In order to serve as many people as possible, case managers are encouraged to close cases as soon as they can and to have family, friends and/or other community agencies provide the long-term, ongoing monitoring. The maximum amount of time a case manager may keep a case open without special exemption is one year. However, it is always possible to re-refer to the program if an individual's condition changes.

LOCATIONS

Seattle Office: 110 Prefontaine Place South, 3rd Floor, Seattle, WA 98104
Kent Office: 525 Fourth Avenue North, Kent, WA 98032
Hours: 8:00 a.m. - 5:00 p.m., Monday-Friday

FEES

There is no fee or charge for case management services. However, donations are appreciated.

TO MAKE A REFERRAL

Call Senior Information and Assistance at 448-3110 (1-800-972-9990 outside of Seattle). Senior I & A is responsible for screening calls and making all referrals to the Case Management Program except for non-English speaking referrals. These can come directly to our Spanish, Japanese, and Chinese workers or via the Special I & A's (ACRS, CISC, and Neighborhood House).

1-73-11167.1

Coordinating Community Services for the Elderly

☐ Seattle Office
110 Prefontaine Place S., 3rd Floor
Seattle, WA 98104
625-4469 or 625-4470

☐ South King County Office
525 - 4th Avenue North
Kent, WA 98032
859-3982

A Cooperative Program of: City of Seattle, King County, United Way of King County

This program complies with all federal, state and local non-discrimination laws

SECTION III AGING

A. GENERAL ECONOMIC AND POPULATION FORECAST FOR KING COUNTY

B. SPECIAL FACTORS IN WORKING WITH OLDER ADULTS

1. COMMON CONCERNS

2. COMMON FEELINGS

SECTION III

A. General Economic and Population Forecasts for King County

During the next four years, general population and economic development in King County is expected to grow at a modest rate. This growth rate, however, is predicted to be much slower than during the past decade. Employment projections for the area show some increase, with the greatest expansion occuring in the fields of electrical instrument manufacturing, trade, finance, business, personnel and health services. In addition, employment in the aerospace industry (Boeing) is not expected to expand greatly but to remain steady at 1980 levels.

In recent years, the monetary policies of the Federal Reserve Board have resulted in reducing the rate of inflation (5% in 1982). This reduction has provided some relief to older persons on fixed incomes who had previously faced double-digit inflation. Although there is little agreement among economists in forecasting future inflation rates and economic growth, there is some consensus in the predictions that inflation will remain at or near the 5% level.

Population forecasts for King County anticipate the general population increasing by approximately 9.4% from 1980 to 1990. An additional factor in the general population growth is the possibility of a U. S. Naval Carrier fleet locating in the area. If Seattle is chosen as the site, an estimated 19,000 persons will relocate to this area.

The older population (60 and over) is expected to expand at a more rapid rate than the general population--increasing approximately 21% during this decade. Within the City of Seattle, however, the older population is not expected to increase, but to remain close to 1980 levels. Therefore, the expansion of the older population is expected to occur in the small unincorporated cities, suburbs and rural areas of the County. As the older population increasingly spreads over a larger geographic area, access to service centers and increased costs in the delivery of services to them may occur.

B. SPECIAL FACTORS IN WORKING WITH OLDER ADULTS

COMMON CONCERNS OF OLDER PEOPLE

LOSSES

Some older people experience many losses:
1. Death of a spouse, friend, relative.
2. Decline in physical health.
3. Loss of status.
4. Less money.

Most older people adjust to these losses with the help of family and friends. When the adjustment is difficult, the Division on Aging's advocates can help by linking these older people to services.

DESIRE TO LEAVE A LEGACY

Most older people want to leave something when they die - work, art, personal possessions, etc. This legacy gives them the feeling of being able to participate even after death.

ELDER FUNCTION

Some older people like to share knowledge and experiences with younger people. This younger generation can benefit by listening and absorbing the cultural writings, arts, music, etc created by their elders.

ATTACHMENT TO FAMILIAR OBJECTS

Objects, pets, and surroundings provide a sense of continuity, aid the memory and provide comfort, security and satisfaction to the older person.

CHANGE IN THE SENSE OF TIME

Older people tend to experience a sense of immediacy and of living for the moment. The elemental things of life - children plants, nature, human touching - assume greater significance as people sort out the more important from the less important.

SENSE OF FULFILLMENT IN LIFE

Many older people become serene and satisfied when they review their lives. One's life does not need to be a "success" to achieve serenity. Sometimes it comes from a feeling of having met life's challanges and even from simply having survived the odds.

COMMON FEELINGS OF OLDER PEOPLE

GRIEF Grief as a result of loss is a predominate factor in aging. It is a natural and necessary process for people to experience. The older person learns to accept the reality of the loss and to begin to find new ways of filling up the emptiness caused by this loss. Grief is usually a difficult process and family and friends can help.

GUILT Some older people may experience guilt feelings as they review their life, especially if they judge themselves or past performances too harshly. The resolution of guilt feelings is essential for many to accept their lives as worthwhile.

LONELINESS With the death of loved ones there is a diminishing circle of significant people who are not readily replaceable. Religion, pets, TV, are not enough to meet older people's emotional needs. The American Dream of independence adds to the isolation problem. Even though increased human contact is needed the older person clings to the idea of living alone and doing for oneself.

ANXIETY Older people need to undergo many new learnings to adapt to physical and environmental changes. With each new learning, anxiety develops - will it be successful and what are the consequences if it fails? Anxiety is seen in many forms: rigid thinking, suspiciousness, illness, fear.

ANGER Older persons may be angry at their inability to control their own lives and at the inevitability of aging and death. Poet Dylan Thomas advises "Do not go gently into that good night".

DEPRESSION Depressive reactions may occur in varying degrees and frequency when older people are having difficulty resolving their grief, feelings of guilt, loneliness, anxiety and anger. This depression may be expressed in certain symptoms such as: insomnia, despair, lethargy and loss of interest. Depression is a legitimate reaction to the many hardships older persons may encounter. As helpers (advocates, visitors, drivers) we may not be successful in helping them move beyond this. However, our time spent with them gives them many special moments and something nice to look forward to.

SECTION IV ALCOHOL AND ELDERLY

A. BRIEF OVERVIEW OF AGING AND ALCOHOLISM

B. THE MASKS ALCOHOLISM CAN WEAR

C. FAMILY ISSUES IN ELDERLY ALCOHOLISM

SECTION IV

A. BRIEF OVERVIEW OF AGING AND ALCOHOLISM

Aging, in relationship to alcoholism, is usually regarded as above the age of 55. This is a fairly new field, and specifically oriented resources are still minimal. Betty Marsh, who is on the "Task Force" says she feels "that it will be 5-10 years before this problem is resolved". Statistical studies tend to show that the elderly are a high risk group for the developement of alcohol abuse.

The casual factors for alcoholism in the aging are many. Some of them are:

1. Grief

   Loss of spouse, and/or other family members, and friends, loss of job, status, and position in the community. Having to move to a smaller home or retirement developement--or in with children. Loss of youth. Loss of health.

2. Boredom

   Lack of interests outside of job. Extra time they are unaccustomed to and don't know how to fill. Lack of old friends due to death and regional relocation. Inability or disinclination to make new friends.

3. Loss of Identity

   The feeling of not being who they were--wage earner, important in the eyes of society and family, etc. Lack of physical ability or interest to do the activities they once enjoyed. Sexual decline--cause or effect?

4. Diminished tolerance to alcohol, and the use of synergistic and/or cross-dependent prescribed drugs.

5. Early onset alcoholics who "beat" the statistics and survived.

To locate and diagnose the older alcoholic is frequently difficult. Most older alcoholics tend to do their drinking in private and are not "visible". Denial in both the alcoholic and their families is probably even greater than in a younger population. The physical and mental deterioration exhibited is just attributed to "old age and senility". Even physicians tend to do this, and further complicate the picture by prescribing sleeping pills, tranquilizers, and/or mood elevators. Then too, symptoms of alcohol abuse are often very similar to Organic Brain Syndrome, Alzheimers and other diseases. "Sympathy" is another factor: "Why not let the poor old thing drink, it's the only thing he has left to enjoy". Depression also complicates the diagnosis.

Treatment of the client must start with a thorough physical examination given by a physician experienced in, and with an empathetic understanding of the problems faced by the alcohol abuser. Once the client has been admitted to a treatment facility, optimal care indicated a longer stay than average. It takes more time to break through the denial of both the client and family. Also, the client has lived his whole life believing he has to be stoical and not discuss his problems, especially not in a group of people. There may be physical problems which would require treatment, and possibly, mental confusion due to aging, alcohol and other drugs.

For a continum of care there should be a coordinated network of providers. As needed, these could range from social services to provide housing and monetary help, to Visiting Nurses for health care, to other home help agencies, such as someone to clean house, to do shopping and provide proper hot meals. They may need drivers to take them to counseling sessions and AA. Maybe, even "visitors" to ease their loneliness.

Most older people enjoy AA and other self help groups, both for the aid and continued sobriety, and for the social aspect. This way they don't slip back into isolation and the feelings of "lost" and "forgotten". Some enjoy a mixed age group and some prefer a group of their peers. They should be able to have a choice.

The basic premise to remember is that the aging come from different racial, social and ethical backgrounds. They have rights, feelings, and knowledge, and a wealth of living experience behind them. In other words, they are us, just a little older, and maybe, a little wiser.

Sally Kopelson
July 29, 1986

B. THE MASKS ALCOHOLISM CAN WEAR

DIFFERENTIAL DIAGNOSIS

ALCOHOLISM	AGING	ADVERSE DRUG REACTIONS
Confusion Clouding of Sensorium	Confusion Clouding of Sensorium	Confusion Clouding of Sensorium
Disorientation Recent Memory Loss Slowed Thought Process	Disorientation Recent Memory Loss Slowed Thought Process	Disorientation Recent Memory Loss Slowed Thought Process
Muscle Incoordination	Muscle Incoordination	Muscle Incoordination
Tremors Inflammation of Joints	Tremors Inflammation of Joints	Tremors Inflammation of Joints
Gastritis Hypertension Depression Congestive Heart Disease Heart Arrythmias Anorexia Altered Response to Stress (Exhausted, sympathetic nervous system response)	Gastritis Hypertension Depression Congestive Heart Disease Heart Arrythmias Anorexia Altered Response to Stress Less Ability to Adjust to Stress (measured by Urine Levels of ACTH and Adrenalin)	Gastritis Hypertension Depression Heart Arrythmias Anorexia Altered Response to Stress Less Ability to Adjust to Stress (measured by Urine Levels of ACTH and Adrenalin)
Malnutrition Excessive Excretion of Magnesium & Potasium	Malnutrition	Excessive Excretion of Magnesium & Potasium
Edema		Edema

SIGNS AND SYMPTOMS OF ALCOHOL PROBLEMS MAY BE MASKED AS AGING, DEPRESSION OR DRUG SIDE EFFECTS.

MEDICAL AND/OR PHYSICAL DISTURBANCES

Odor of alcohol on breath, on person and throughout room.
Alcoholic facies - vascular engorgement, bulbous nose, spider-angioma, orbital edema (usually seen in the late-stage alcoholic).
Sallow Skin.
Yellow or bloodshot eyes.
Increased incidence or infection.
Abnormal bleeding.
Edema (water retention of hands, ankles and feet)
Gastric disturbances (frequent heartburn and indigestion, ulcers, pancreatitis, diarrhea, etc.)
Overweight and underweight syndrome.
Cigarette or other burns on hands, chest or clothing, furniture or carpet.
Bruises - especially furniture height and back of hands.

Behavior Signs

Excessive smoking.
Changes in sleep patterns, especially insomnia.
Little or no appetite.
Nesting - a favorite chair with a close table to hold ashtray, drinks, etc., where one can sit and drink, usually facing the TV.
Reports of excessive drinking by family and/or others.
History of alcohol-related arrests.
Unkempt personal appearance.
Slovenly surroundings.
Persistent financial difficulty.
Frequent hand tremors.
Persistent vague somatic complaints (headaches, fatigue and general malaise.)

Disturbances of Mood

When drinking is discussed: evasiveness, open hostility, denial, or manipulation (subject is changed, client takes over the interview).
Moodiness and mood swings; outbursts of anger or tearfulness, sucicdal gestures.
Depression; lack of motivation.
Complaints of loneliness and helplessness.
Vague fears; free-floating anxiety.

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C. FAMILY ISSUES IN ELDERLY ALCOHOLISM

I. ENABLING: The family, friends and members of helping professions often inadvertently enable the elderly alcoholic to continue drinking longer and more comfortably by rescuing him/her from the painful results of the drinking. This process is called "enabling" and may occur in the following ways:

A. Denial

The stigma attached to alcoholism often leads the family of the alcoholic to deny the existence of an alcohol problem as much as or more than the alcoholic himself does.

The elusive nature of the illness contributes to prolonging denial. There often are periodic remissions during the relentless downward progression of the disease. These periods, when the alcholic seems to have control over the drinking, easily contribute to the denial of the family that there is a problem.

B. Attitudes and Myths

Hopelessness and helplessness on the part of concerned others often prevent the referral of the elderly alcoholic for help. "What's the use? He/she will never stop drinking." "You can't teach an old dog new tricks" is a false belief which contributes to the feeling of hopelessness helplessness.

"Drinking is one of the few pleasures Mom/Dad still has." These words describe the myth that alcohol brings happiness - a belief commonly held by families who are unaware that the loneliness and depression they think alcohol is relieving are actually the miserable results of the escessive drinking.

C. Mistaken Diagnosis

Alcoholism may masquerade as senility, depression and/or other drug side effects and may, therefore, go unrecognized. Many symptoms of these conditions are identical. The need for a differential diagnosis by concerned others, i.e., family, friends and members of the helping profession, is critical. When any or all of these conditions exist simultaneously with alcoholism, it is necessary to remove the alcohol before an accurate assessment may be made of the others.

II. PARENTING: Elderly alcoholics are particularly vulnerable to the role reversal which often occurs between the elderly and younger members of the family. Adult children assume the parent role as excessive drinking renders the alcoholic less and less able to manage his life. Health problems increase and as the situation

deteriorates, concerned others begin protecting and assuming responsibility for the alcoholic. As the control over his life is taken over more and more by the children who make decisions and offer unrequested advice, the self-esteem of the alcoholic plummets deeper. The well-meaning family becomes frustrated and exhausted and family relationships deteriorate. At this point there is a need for education of the family about alcoholism as well as family therapy.

It is often difficult to assess the difference between offering a legitimate helping hand due to some of the natural impairments which result from the aging process and falling victim to the manipulations of a practicing alcoholic.

"Parenting" may be perceived by the elderly as a colossal "put-down". They respond best to attitudes of respect and approaches which build self-confidence and self-esteem.

III. A FAMILY ILLNESS: Alcoholism in the elderly affects family members in some unique ways. Most severly affected, next to the spouse if there is one, are the adult sons and daughters who often feel guilt about the uncontrolled drinking of their loved ones. Though this process occurs in families of younger alcoholics, the effect seems more profound in the case of the elderly where the results of the drinking are usually more critical and life-threatening. Adult sons and daughters and spouses feel guilty and responsible yet exasperated and helpless. Feelings become jumbled and commonly include, besides guilt, resentments, anger, frustration, helplessness and hopelessness. Emotional illness is not an uncommon result. The family often goes to elaborate lengths in attempting to stop or control the drinking. Family relationships are undermined in the process and bitter alienation may eventually occur.

Education about alcoholism and counseling are important to include in the treatment of the family. Communication patterns are usually damaged and can be improved in family counseling sessions.

It is essential to consider all of the above family issues when planning treatment for the elderly alcoholic.

*Senior Alcohol Services P.O. Box 425 Vancouver, WA 98666

SECTION V THE FAMILY CONFERENCE

A. FAMILY INTERVENTION

B. GUIDELINES FOR THE FAMILY PROBLEM SOLVING CONFERENCE

C. EXPLANATIONS OF DYSFUNCTIONAL BEHAVIORS IN THE FAMILY CONFERENCE

D. FAMILY ILLNESS IN CHILDREN

E. FAMILY ROLES

SECTION V

A. FAMILY INTERVENTION

THE PRESENTING SITUATION

76 year old caucasian female, married 40 years plus -- her name is Elaine, her husband's name is Ralph. They will be referred to as Mr. and Mrs. C. They have lived in a rural area for more than 20 years. Mrs. C's functional level has been declining over the past 2 or 3 years. She is probably diabetic, seems to be quite forgetful and confused. She is on medication for High Blood pressure and a diuretic. She is not cooking or cleaning. She seems to need reminding to attend to her personal care need.

Ralph has some old friends he likes to spend time with playing cards and pool. He has some health problems also, he is doing minimal work at home. He is gone frequently.

One daughter, Grace, is in her 50's, is married, lives about 5 miles from her parents. Her husband, Bill is recently retired. Grace is coming almost daily to assist with cooking and cleaning for Elaine and Ralph.

A crisis has arisen because Bill (Grace's husband) who has retired, is refusing to let Grace spend so much time at her parents' home.

Attending this family conference will be:

Elaine and Ralph C.
Grace and Bill
Kathy, another daughter who is single and lives about 50 miles from Elaine and Ralph.
Julie, a granddaughter who is in college about 30 miles distance. Her mother is Kathy.

Two Staff Members
One is a Case Manager specializing in Aging.
Another is a Counselor who specializes in Alcohol Treatment.

*See following page for:

"Helpful Guidelines for the Problem Solving Conference"

B. GUIDELINES FOR THE FAMILY PROBLEM-SOLVING CONFERENCE

STEP ONE: PLAN THE FAMILY CONFERENCE

Involve ALL family members - even ones far away.
Involve your parent in the conference.
Avoid dictatorial rule by one member.
Have the conference face to face if possible.

STEP TWO: FINDING OUT WHAT DOES MOTHER HAVE TO SAY?

If at all possible don't allow the parent to let you make the final decisions.
Lay out all the data and encourage the parent to decide.
Remember no decision is irreversible.

STEP THREE: DECIDING WHO ELSE IS INVOLVED

Involve everyone that has an investment in the parent.
This will avoid scapegoating and feelings of resentment later on.
Ask yourself: Who is Most Concerned?
Who is Most Affected?
Who has Resources to Offer?

STEP FOUR: GIVING THE FLOOR TO ALL

Give ALL those attending a chance to speak their minds.
Ask for their intentions, preferences, capabilities.
Keep members on target.
Be open to new learnings about yourself, and your role in the family.

STEP FIVE: IDENTIFY THE PROBLEM

Gather as much information about the parent's total condition (physical, psychological, social, etc.)
Break down the problems into identifiable, do-able steps.
Prioritize which part of the problem should be dealt with first.

STEP SIX: DISCOVERING WHO WILL MAKE COMMITMENTS

Discover how much responsiblity will each family member really take.
Be realistic with yourself, with each other.
This may be a painful and disillusioning time.
Be open to trial and error - several plans may need to be tried.

STEP SEVEN: SETTING PRIORITIES

Step back from the group process and consider family and individual priorities.
Ask yourself if I take on major responsibility for my mother's care - how will this affect my children, my spouse, my community work?
Don't commit yourself to something you may have to back out of

later - consider your limits.

STEP EIGHT: REACHING AN AGREEMENT

Be open to others' ideas, solutions.
You may end up with a solution totally unexpected from what you started with.
Beware of "traps" that undermine real agreement - try to

1) Be absolutely honest about the effects aggreements may have on your marriage, your health, your feelings towards other family members.

2) Express negative feelings, clear the air. Its ok to want to feel loving and respectful of an aging parent but still have angry and resentful feelings.

3) Don't make unrealistic promises: Words like every, never, forever, are always dangerous: "You won't EVER GO to a nursing home, we promise, Mom." Take a more moderate stance.

4) Don't jump the gun and allow yourselves to come to a quick agreement just to get on with it - think through consequences and implications of any action step. It will make it easier to accept difficulties in the long run.

*Taken from: "You and Your Aging Parent" Silverstone and Hyman 1982 Pantheon Books, Chapter 10.

C. EXPLANATIONS OF DYSFUNCTIONAL BEHAVIORS IN THE FAMILY CONFERENCE

Because this family is dysfunctional and has been for some time there are several possible "roles" they may be living out.

The intervention team needs to be prepared for the covert, as well as overt, behavior they may observe. They need to be knowledgeable regarding the defense mechanisms that are often used.

It's important to recognize, through each of these roles the individual believes on a subconscious level, they are "helping" the family. These are attempts to avert a crisis or maintain the status quo.

The Grid and Family roles statement that follows are useful in understanding the many dynamics present when working with alcoholic dysfunctional families.

"The Family Trap" by Sharon Wegscheider, Johnson Institute, 1976

FAMILY ILLNESS IN CHILDREN

FAMILY ROLES	VISIBLE QUALITIES	INNER FEELINGS	PEPRESENTS TO FAMILY	CHARACTERISTICS	POSSIBLE FUTURE CHARACTERISTICS	
					WITHOUT HELP	WITH HELP
HERO (Often the eldest child)	VISIBLE SUCCESS DOES WHAT'S RIGHT	INADEQUATE	SELF-WORTH (Family can be proud)	HIGH ACHIEVER GRADES FRIENDS SPORTS	WORKAHOLIC NEVER WRONG RESPONSIBLE FOR EVERYTHING	ACCEPT FAILURE RESPONSIBLE FOR SELF, NOT ALL GOOD EXECUTIVES
SCAPEGOAT Often youngest child)	HOSTILITY DEFIANCE ANGER	HURT GUILT	TAKES FOCUS OFF THE ALCOHOLIC	NEGATIVE ATTENTION WON"T COMPETE WITH "FAMILY HERO"	UNPLANNED PREGNANCY TROUBLE MAKER IN SCHOOL & LATER IN OFFICE	ACCEPT RESPONSIBILITY GOOD COUNSELORS COURAGE ABILITY TO SEE REALITY
LOST CHILD	WITHDRAWN LONER	LONELINESS UNIMPORTANT	RELIEF (One child not to worry about	"INVISIBLE" QUIET NO FRIENDS FOLLOWER TROUBLE MAKING DECISIONS	LITTLE ZEST FOR LIFE SEXUAL IDENTITY PROBLEMS PROMISCUOUS OR STAY ALONE OFTEN DIES AT EARLY AGE	INDEPENDENT TALENTED CREATIVE IMAGINATIVE SELF-ACTUALIZED
MASCOT (Usually the youngest child)	FRAGILE IMMATURE NEEDS PROTECTION	FEAR	FUN & HUMOR (COMIC RELIEF)	HYPERACTIVE LEARNING DISABILITIES SHORT ATTENTION SPAN	ULCERS, CAN'T HANDLE STRESS COMPULSIVE CLOWN MARRY "HERO" FOR CARE REMAINS IMMATURE	TAKE CARE OF SEL NO LONGER CLOWN FUN TO BE WITH GOOD SENSE OF HUMOR

D. FAMILY ROLES

IMPORTANT POINTS

The dependent, as he becomes a victim of his addiction, covers his decreasing self-worth with protective behaviors.

The spouse covers his growing pain by developing protective behaviors.

The children cover their growing pain by developing protective behaviors.

All family members are out of touch with their power to generate good feelings for themselves.

All family members feel powerless to change the situation.

Each family member carries his dysfunction with him as part of his personality pattern.

Either their dysfunctions will tend to interfere with their outside life...

Or, they develop two personalities, one for the family and one for the outside world.

Either way, they are playing a survival role which is different from who they really are.

At this point, each family member needs treatment.

SECTION VI BIBLIOGRAPHY

SECTION VI ADULT CHILDREN OF ALCOHOLICS (ACOA) BIBLIOGRAPHY

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